

# Welcome To

Thank you for choosing Pick PT.

We look forward to helping you meet your rehabilitation needs.

To help us serve you more efficiently, please fill-out, read, sign, and date in the designated areas.

Patient's First Visit Date		Physical Therapist's Name		Patient's <u>New</u> Account Number	
<b>Patient Information</b>					
Patient Name <i>(Last, First Middle Initial)</i>			SSN <i>(Social Security Number)</i>		DOB <i>(Date Of Birth)</i>
Sex <input type="checkbox"/> M <i>(Male)</i> <input type="checkbox"/> F <i>(Female)</i>	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		Email		Home or Cell Phone
Street Address <i>(Mailing Address)</i>			City, State, Zip		
When was your last physician visit? <i>(Date/Dates)</i>	Referring Physician's Name	Was this an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of the accident?	
Tell Us About Your Injury				Attorney's Name	
Whom may we call in case of emergency?		Relation to you?		Phone	
<b>Whom may we thank for referring you to our clinic?</b>					
<input type="checkbox"/> Attorney <input type="checkbox"/> Billboard/Sign/Location <input type="checkbox"/> Doctor <input type="checkbox"/> Insurance Provider <input type="checkbox"/> Newspaper <input type="checkbox"/> Phone Book <input type="checkbox"/> Radio <input type="checkbox"/> Return Patient <input type="checkbox"/> Television <input type="checkbox"/> Website <input type="checkbox"/> Family Or Friend <input type="checkbox"/> Other: _____					
<b>Responsible Party</b>					
Responsible Party Name or Business Name		Relationship to Patient		Phone	
Street Address <i>(Mailing Address)</i>			City, State, Zip		
Insured Party's SSN <i>(Social Security Number)</i>		Insured Party's DOB <i>(Date Of Birth)</i>	Other Information		
<b>Responsible Party Employer</b>					
Employer's Name			Employer's Phone		
Employer's Address			City, State, Zip		
<b>Patient Or Spouse Employer</b>					
Employer's Name			Employer's Phone		
Employer's Address			City, State, Zip		
<b>Consent For Care And Treatment</b>					
I, the undersigned, do hereby agree and give my consent for Pick PT to furnish medical care and treatment to _____ as considered necessary and proper in diagnosing or treating his/her physical and condition. <span style="float: right;"><i>(Patient's Name)</i></span>					
_____ Patient and/or Guardian Signature		_____ Patient and/or Guardian Print Name		_____ Today's Date	

## Benefit Assignment/Release Of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Pick PT. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

\_\_\_\_\_

Patient and/or Guardian Signature

\_\_\_\_\_

Patient and/or Guardian Print Name

\_\_\_\_\_

Today's Date

## Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Pick PT.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

## Insurance Information

Primary Insurance		Mailing Address (City, State, Zip)			Phone
Group and/or Claim #		Member Id #		Adjuster/Case Manager	
Co-Pay or %	Deductible	Amount Met	Max Pt. \$ /Visits	\$/Visits Used	Effective Date
Secondary Insurance		Mailing Address (City, State, Zip)			Phone
Group and/or Claim #		Member Id #		Adjuster/Case Manager	
Co-Pay or %	Deductible	Amount Met	Max Pt. \$ /Visits	\$/Visits Used	Effective Date

## Patient's Responsibility

Ded To Meet	Co-Pay/Coins	Arrangement
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*NOTE: Estimated coverage information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.*

The above information has been read and explained to me.  
I understand my full responsibility for the payment of my account.

\_\_\_\_\_

Patient and/or Guardian Signature

\_\_\_\_\_

Patient and/or Guardian Print Name

\_\_\_\_\_

Today's Date

\_\_\_\_\_

Authorized Pick PT Representative's Signature

\_\_\_\_\_

Authorized Pick PT Representative's Print Name

\_\_\_\_\_

Today's Date

